INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

Client Information and Consent (Please read this form carefully and completely)

■ You have the right to be informed; be given information about your care and to ask questions.
■ You have the right to accept or reject all or any part of your care plan.
■ You have the right to revoke consent verbally or in writing to any member of the treating staff for any reason at any time.
■ You have the right to language/interpreting services. Services Requested: ☐ YES ☐ NO
■ You have the right to a copy of this Consent: Copy Requested? ☐ YES ☐ NO

Emergency Treatment: In certain emergencies, medication may be given to you when it is impractical to obtain consent. However, once the emergency has passed, medication will continue with your informed consent. *(An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others).*

Your Physician is prescribing the following psychotropic medication(s) for you:

Medication(s) Name	Medication Info. Sheet Given (check box) ☑
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO

In order to be informed and give consent, your doctor will discuss the following information with you:

Verbal Information Discussed with Client

1. Nature and seriousness of your mental illness
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s)
3. Reasonable alternative treatments and why doctor is recommending this particular treatment
4. Type, range of frequency and amount (including PRN orders), method (oral or injection), duration of taking medication(s)
5. Probable side effects known to commonly occur, and any particular side effects likely to occur with you
6. Possible additional side effects which may occur when taking medication(s) beyond three months
7. If prescribed a ***conventional/typical or atypical antipsychotic medication,*** information will be given to you about **tardive dyskinesia,** a possible side effect caused by ***typical/atypical antipsychotic medication***. It is characterized by involuntary movements of the face or mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

Client: _____

MR/Client ID #: _____

Program: _____

Client's Consent:

Based upon the information I have read, discussed and reviewed with my doctor:
(check one of the following)

- ❑ I understand and give consent to the use of the psychotropic medication(s) on page one.
- ❑ I give verbal consent only; refuse to sign form.
- ❑ I do not approve/consent to the use of the psychotropic medication(s) listed below.

Please list: _____

_____
Signature of Client/Legal Rep./Guardian Date

Doctor's Statement:

I have reviewed, discussed and recommend the medication plan (page 1) for above client and:

- ❑ Client gives consent to take these medications.
- ❑ Client gives verbal consent, but unwilling or unable to sign.
- ❑ Emergency. Given medication without consent.
- ❑ Unable to understand risks and benefits, and therefore cannot consent.
- ❑ Other Comments: _____

_____

_____
Psychiatrist's Signature Date

_____
Printed Name

_____
Witness Signature (if applicable): Date